# Nursing home review improves

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## Manager enthused about results of state inspection

By MATTHEW McCORMICK
Staff Writer

Some door latches need replacing and one resident had to wait a bit too long for a shave, but few other issues arose during the state's annual review of the county nursing home.

"This is the best survey I've been involved in for 10 years. It was evident that the staff has done a really good job in the past year," director of nursing Heidi Smith said in an interview Wednesday.

Unity

Officials from the state Department of Health and Human Services arrived at the home in mid-October and spent a week examining nearly every facet of the facility's operation, Sullivan County Health Care administrator Scott Wojkiewicz said.

"They come in and dig in every nook and cranny of the building they can get their hands in," he said.

What they look for, Wojkiewicz said, are any violations of the thousands of pages of state and federal regulations that guide nursing home practices across the country.

The investigators found just five such infractions, half the number of violations that surveyors found in 2005. In that year, the home was cited for quality of care and life safety transgressions, including failure to properly administer medication to one resident and to properly test fire extinguishers.

In 2006, the most widespread infraction was the presence of "roller latches" on two of the facility's four floors. A March 2003 regulation required the replacement of that type of latch, which allows a door to be opened with a push, with latches that require the turn of a knob to open.

Two of the facility's violations had to do with the disbursement of residents' trust funds upon their discharge or death. In several instances, the nursing home mailed checks to former residents or the executors of their estate containing the balance of their trust fund but did not follow up to ensure those funds were cashed as regulations require.

A sample of two of 24 residents also revealed a failure to follow through on some

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aspects of the comprehensive care plan created for each patient upon their arrival at the facility.

In the first instance, a patient's plan called for weekly weight documentation but was not put on the scales during the second week of October.

The other patient's plan called for staff to shave the person with an electric razor. Wojkiewicz said the resident had been refusing that care for some time but, after the administrator told him his beard could easily be taken care of, decided to request a shave the day the surveyors were on his floor.

When the nurses went to fulfill the request, they found the resident's shaver broken and Wojkiewicz said that in the surveyor's opinion took too long to buy a new one.

"The trend in New Hampshire is for more difficult surveys," he said. "The surveyors themselves are digging much deeper than they have before."

The facility's final infraction had to do with medication storage. Surveyors witnessed a nurse leave three vials of an antibiotic unattended at a nurse's station desk.

Wojkiewicz said he already has taken steps to address the investigator's findings, including ordering positive latches for residents' doors and establishing a plan for following up on trust fund checks.

***Matthew McCormick can be reached at mccormick@eagletimes.com or (603) 543-3100 ext. 104.***